Clear Form

PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP
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ADDITIONAL INSURED APPLICATION

Claims-Made Coverage
Allied Health Professionals

COVERAGE ADD DATE (MM/DD/YYYY):	POLICYHOLDER NAME:	POLICY #:

1. APPLICANTS NAME:

2. PROFESSIONAL DESIGNATION:

3. EMPLOYED BY: ☐ SELF/INDEPENDENT CONTRACTOR ☐ POLICYHOLDER
☐ FACILITY: _____ ☐ OTHER (EXPLAIN IN *REMARKS*)

4. RESIDENCE ADDRESS (STREET, CITY, STATE AND ZIP):

5. EMAIL:

6. DAYTIME PHONE:
( )

7. DATE OF BIRTH (MM/DD/YYYY):

8. SSN #:

9. DRIVER'S LICENSE:
ST: NUMBER:

10. PROFESSIONAL LICENSE(S):
ST: NUMBER: ST: NUMBER: ST: NUMBER:

11. NURSING/PROFESSIONAL SCHOOL (INSTITUTION/FACILITY NAME AND CITY/STATE):

GRADUATION (MM/YYYY):

12. SCHOOL OF ANESTHESIA (INSTITUTION/FACILITY NAME AND CITY/STATE):

GRADUATION (MM/YYYY):

13. DATE OF CRNA CERTIFICATION (MM/DD/YYYY):

14. CERTIFICATION IN THE STATE OF:

15. RECENT PRACTICE LOCATIONS: (*List all others in "Remarks" or attach a current and complete CV – show prior 10 years.*)

FROM (MM/YYYY):	TO (MM/YYYY):	FACILITY NAME:	CITY/STATE:

16. SPECIAL CIRCUMSTANCES: (*Please explain all "YES" answers in the "Remarks" section or attach a narrative description*)	YES	NO
a. Have you ever been investigated or disciplined by the professional licensing authority in any state, or has a licensing authority ever suspended, restricted, revoked, denied renewal or taken other action against your professional license whether voluntarily agreed to or not?	☐	☐
b. Have you had restrictions placed on your privileges or restrictions placed on the type of cases assigned to you by a hospital, other healthcare facility, or a practice entity, or have you ever been investigated for patient care or safety reasons and found not to have met the standard of care?	☐	☐
c. Have you voluntarily agreed to limitations on your privileges or limitations on the type of cases assigned to you by a hospital, other healthcare facility, or a practice entity?	☐	☐
d. Have you ever had membership or participation restricted by any professional society or health insurance plan or organization including Medicare and Medicaid programs?	☐	☐
e. Have you ever been convicted of a felony or misdemeanor or have you ever been named as a defendant in a criminal or civil tort case other than a medical malpractice case?	☐	☐
f. Have you ever had; or have you ever been investigated for; or have you ever received treatment for an alcohol or substance abuse problem; or have you been convicted of an alcohol and/or drug related offense?	☐	☐
g. Have you ever had any personal health problems that might affect your professional health care practice; or have you ever been under psychiatric care or treated for mental illness?	☐	☐
h. Does any part of your practice fail to meet the ASA Standards for Basic Anesthetic Monitoring?	☐	☐
i. While working for the Policyholder indicated at the top of this page, will you be providing anesthesia care to patients not seen previously by an anesthesiologist, or where no anesthesiologists directly participate in cases with you?	☐	☐
j. Are you engaged in any moonlighting activity? If YES, please explain how you are insured for this activity in Remarks.	☐	☐
k. Will you have other medical malpractice insurance coverage in force after this coverage is effective? (Please attach a copy of the policy, or describe the coverage including the insurer, limits and any restrictions.)	☐	☐

Your signature is required on page 2

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17. CLAIM INFORMATION: (*Other than claims previously reported to Preferred Physicians Medical- please explain all "YES" answers*)	YES	NO
a. Have you ever been notified either directly or indirectly of, or are you aware of your involvement in a malpractice claim or suit?	☐	☐
b. Are you aware of any incidents, circumstances, adverse events or sentinel event which might give rise to a claim or suit against you?	☐	☐
c. Are you aware of any claim, suit, incidents, circumstances, adverse events or sentinel event involving you that has not yet been reported to your current insurer, or which has not been accepted for coverage by your current insurer?	☐	☐

DATE OF INCIDENT MM/DD/YYYY	ALLEGATION / INCIDENT DESCRIPTION (PLEASE INDICATE THE CURRENT STATUS AND ANY PAYMENTS MADE ON YOUR BEHALF	REPORTED TO INSURER YES	NO
		☐	☐
		☐	☐

REMARKS

AGREEMENT AND RELEASE

All applicants must sign this release

APPLICATION AGREEMENT AND RELEASE AUTHORIZATION

1. I understand that this is an application for insurance as an additional insured and not an insurance binder.
2. I have accurately and truthfully completed the application and have not withheld any information that is reasonably likely to influence the judgment of the Company in considering this application. I agree to notify Preferred Physicians Medical of any change in the information provided. I understand that any misrepresentation or concealment of information may void all coverage extended by Preferred Physicians Medical.
3. For the purpose of evaluating this application, I authorize Preferred Physicians Medical to obtain information about me and my practice from my past or present employers, professional associations or societies, insurance providers or consultants, health care facilities, other health care providers, licensing boards, governmental agencies and credit bureaus. I further authorize Preferred Physicians Medical to obtain information regarding civil litigation or criminal prosecution. I agree to release from liability and hold harmless Preferred Physicians Medical and any individual or organization providing information pursuant to this release.
4. I have accurately and truthfully reported in this application any adverse outcomes, circumstances or events that could give rise to a claim. I understand that coverage for same will not be provided unless specifically accepted by Preferred Physicians Medical.
5. If this application is accepted, I understand that Preferred Physicians Medical may be asked to provide credentialing information on my behalf to hospitals, insurance entities, credentialing programs, and governmental agencies. I agree to release from liability and hold harmless Preferred Physicians Medical in providing this information.

Applicant's Signature _____ Date _____

NOTICE

This application is provided by a risk retention group. A risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for a risk retention group.